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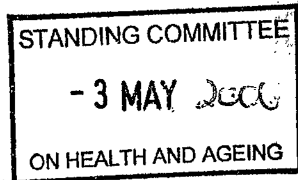

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

SUBMISSION TO THE HOUSE INQUIRY INTO HEALTH FUNDING

Presented to Standing Committee on Health and Ageing

Prepared by the

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INTRODUCTION

The APA congratulates the Standing Committee on Health and Ageing for undertaking this inquiry in parallel with the Productivity Commission's Health Workforce Inquiry. There is a strong link between health workforce and health funding arrangements in Australia.

The APA contends that many of the Productivity Commission's recommendations, if implemented, would have a positive impact on health funding in the private sector. Of note are the recommendations contained in Chapter 8 of the Commission's research report.

The APA supports all of the Productivity Commission's recommendations and urges the Committee on Health and Ageing to endorse the package of recommendations, in addition to making recommendations of its own.

In September of 2004 the APA published its Platform. The Platform is a statement on principles on which all APA positions are based. The following principles are of relevance to this inquiry:

The APA contends that all public health services, including physiotherapy services, should be directly funded by the Federal Government.

The APA supports a universal, publicly funded Medicare system.

The APA contends that Medicare should be extended to cover the evidence-based management of selected conditions by physiotherapists.

The APA contends that a viable private health sector is an essential component of the health system in Australia.

The APA supports the GST free status of mainstream healthcare services.[1]

The APA would be pleased to provide additional information on any aspect of this paper and to appear before the Committee to explain its perspective in detail.

[1] The APA Platform is available at: http://apa.advsol.com.au/physio_and_health/public/download/APA_platform.pdf

RECOMMENDATIONS

MBS

1. That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.
2. That referral arrangements for X-rays of the limbs be changed so that patients receive the same rebate on physiotherapist referral as on GP referral for the service.
3. That a physiotherapy MBS item be introduced for the treatment of Indigenous children, on referral from the GP conducting the Indigenous child health check.
4. That an outreach physiotherapy MBS item be introduced for the treatment of Indigenous children, on referral from the GP conducting the Indigenous child health check.
5. That similar items be created for therapy and preventive care for adults who have an Indigenous adult health check (MBS item 710) billed.
6. That new MBS items be introduced for the management of specified conditions by specified practitioners where there is evidence of the effectiveness and cost effectiveness of the intervention.

Fund Pooling

7. That Division of General Practice be transformed into Divisions of Primary Care with membership open to all registered health professionals with a governance structure that reflects this diversity. Divisions of Primary Care should receive funding from a state/Commonwealth funding pool to deliver multidisciplinary services.
8. That the state and Commonwealth funds be pooled to trial a multidisciplinary care centre in each state and territory.

Citizen engagement

9. That the Commonwealth fund a process of citizen engagement in decision making about the allocation of health funding.

Regulation of private health insurance

10. That health insurance funds be required to waive the 12-month waiting period for pre-existing conditions for individuals who have current policies with other funds.
11. That health insurance funds be required to give a statutory notice period before reducing existing rebate arrangements.

MAKE MEDICARE WORK SMARTER

As it stands Medicare funding is a monopoly which creates perverse incentives to utilise doctors' services even when they are not the most appropriately skilled professionals to provide those services.

Recent Commonwealth initiatives, such as the provision of limited allied health services under the Enhanced Primary Care program, have begun to recognise this fact but have not gone far enough. The APA is satisfied that in the long term the recommendations in the Productivity Commission's Health Workforce Research Report will improve the operation of Medicare but submits that short term changes could yield immediate savings both of health professionals' time and tax-payer dollars. Below are a series of recommendations on making Medicare work smarter.

Specialist referral arrangements

The APA contends that MBS referral arrangements in relation to specialist consultations are inefficient. A conservative estimate of the number of services private physiotherapists provide per annum is 15 million[2]. This figure is based on private health insurance rebate information and accident compensation statistics. Most of these consultations involve the physiotherapist assessing, diagnosing, and managing the patient's condition independently or in co-ordination with a range of other health professionals as required.

However, on some occasions, the physiotherapist diagnoses a condition that requires care by a medical specialist. The physiotherapist then advises the patient that they must see a specialist, but in order to attract a Medicare rebate for the specialist's services, a GP referral is required. Naturally the patient attends the GP, although there is no clinical reason to do so. Thus, the patient's and GP's time is wasted and an MBS consultation is billed unnecessarily. There is no clinical reason why the patient should not receive a rebate on the physiotherapist's referral. In fact, the current system can lead to a delay in patients receiving the required intervention and thus exacerbate the consequences of their injury or condition. There is precedence for this change to MBS referral for physiotherapy arrangements, as patients currently receive a full rebate on an optometrist referral to an ophthalmologist.

If the patient has a GP, under this arrangement the doctor can be kept fully informed of the patient's management by the physiotherapist and the specialist by letter or in the future by the use of a shared electronic health record.

Reforming the referral arrangements requires only minor legislative change and will result in workforce and cost savings, and enhanced patient care. The APA contends that the current referral arrangements do not contain costs but

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2 There are over 6.2 million consultations rebated under private health insurance and 1.05 million by the Department of Veterans' Affairs. In addition to these consultations, there are services rebated by Comcare, transport accident and workers' compensation authorities and private sector consultations for which no rebate is paid.

rather lead to unnecessary expenditure on GP visits, waste the valuable time of GPs, waste the patient's time, and delay treatment.

Recommendation:

1. That patients referred by physiotherapists to medical specialists be eligible to claim the same MBS rebate that applies upon GP referral.

Diagnostic imaging

The APA contends that current diagnostic referral arrangements are inefficient and that access to imaging tests for medical practitioners and allied health professionals is inequitable. Physiotherapists graduate with the competence to interpret a variety of diagnostic imaging tests[3], including X-ray images, and regularly refer patients to radiology to assist with diagnosis and to determine appropriate treatment. Indeed, their competence is acknowledged by virtue of the fact that they have full referral rights in regard to hip, pelvis and spinal X-rays and partial referral rights for X-rays of the extremities.

However, there is currently a differential in the Medicare rebate to patients depending on which health professional refers them for X-ray. Only doctors and registered podiatrists are able to refer for R X-rays[4] of the foot and ankle[5], and only doctors are able to refer for R X-rays of the hand, arms, scapula or clavicle[6]. All other health professionals are required to use the NR item number which attracts only 85% of the rebate available to patients of GPs[7].

This situation introduces inefficiency to the health system whereby patients attend a GP for the sole purpose of obtaining an X-ray referral. This wastes both GP and patient time and results in delayed access to appropriate treatment. Physiotherapists are the largest group of professionals referring for NR X-rays, and therefore physiotherapy patients are most frequently affected by this inequity.

To quantify and assess this inefficiency the APA undertook a Commonwealth funded study into the diagnostic imaging patterns of physiotherapists[8]. This was completed in 2004 and presented to the Department of Health and Ageing. Based on the MBS rebates at the time, it was found that the current referral arrangement for physiotherapists was costing Medicare at least $1,040,567 per year. Additional costs are incurred by patients in payment of gap fees for GP visits. Unquantifiable costs include the patients' time and the lost opportunity for timely intervention caused by the delay in patients receiving an X-ray examination. It was also estimated that approximately 9460

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3 Training in interpretation of diagnostic imaging tests is integrated throughout the four year physiotherapy curriculum and each unit of the syllabus includes the interpretation of imaging tests relevant to the systems under study. Diagnostic imaging interpretation is also included as part of clinical education.

4 Referral (R) X-rays and non-referral (NR) are the Medicare descriptors used to distinguish between those examinations that receive a full MBS rebate and those that receive only an 85% rebate.

5 MBS 2003, pg. 413.

6 ibid

7 ibid

8 A full copy of the report can be downloaded from the APA website. URL address: https://apa.advsol.com.au/staticcontent/staticpages/submissions/PhysiotherapistsDiagnosticImaging.pdf

hours of GP time was wasted per year, the equivalent of almost five fulltime GPs. The study found that small changes in referral arrangements would save over $1 million and 10,000 hours of GP time per year.

Recommendation:

2. That referral arrangements for X-rays of the limbs be changed so that patients receive the same rebate on physiotherapist referral as on GP referral for the service.

Indigenous health checks

The APA applauds the Government's decision to introduce an MBS item for GPs to conduct annual health checks for Indigenous children. However, the APA is concerned that there is no funding for physiotherapy interventions that may be indicated by the check. In addition, the APA submits that Indigenous adults would also benefit from physiotherapy care provided under referral from GPs who have completed an Indigenous adult health check (MBS item 710).

Physiotherapists currently deliver primary health care services to Indigenous children across Australia in a wide variety of settings; they work with a wide range of health professionals, and are key members of multidisciplinary child development teams.

Indigenous children have a number of health problems including: high rates of premature birth and low birth weight[9], growth problems due to poor nutrition and other environmental factors, asthma and respiratory conditions[10], acute infections, and high rates of injury[11], particularly from road accidents[12]. Physiotherapy may be indicated as an effective primary treatment or as part of a comprehensive response to the particular health needs of a child. Physiotherapists have expert clinical skills in:

- Helping to prevent secondary complications of cerebral palsy[13], for example joint contracture, and can assist in maximising physical function and independence[14].

- Educating parents about handling, positioning, and activities to promote better development in preterm infants[15].

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9 Australian Institute of Health and Welfare, Australia's Health 2004. Canberra: Australian Institute of Health and Welfare, 2004.
10 Glasgow NJ, Goodchild EA, Yates R, Ponsonby A-L. (2003) Respiratory health in Aboriginal and Torres Strait Islander children in the Australian Capital Territory. *Journal of Paediatric and Child Health* 39(7):534-539.
11 Moller J, Thomson N and Brooks J (2004) Injury Prevention Activity Among Aboriginal and Torres Strait Islander People Vol 1: programs, projects and actions. Report to the Australian Government Department of Health and Ageing, August p, 11.
12 Cercarelli LR and Knuiman MW (2002) Trends in road injury hospitalisation rates for Aboriginal and non-Aboriginal people in Western Australia, 1971–97. *Injury Prevention,* 8:211–215.
13 There is a risk associated with preterm infants and cerebral palsy (Reddihough DS, Collins KJ (2003) The epidemiology and causes of cerebral palsy *Australian Journal of Physiotherapy* 79:7-12).
14 Functional strength and dexterity training delivered to groups of children with cerebral palsy have been shown to improve strength and functional performance; these improvements are maintained over time (Blundell SW, Shepherd RB, Dean CM and Adams RD (2003) Functional strength training in cerebral palsy: A pilot study of a group circuit training class for children aged 4–8 years. *Clinical Rehabilitation* 17:48–57).
15 Chiarello LA and Palisano RJ (1998) Investigation of the effects of a model of physical therapy on mother-child interactions and the motor behaviours of children with motor delay, *Physical Therapy,* 78:180-194; Lekskulchai R and

- Treating a range of musculoskeletal injuries and minimising the long term disability arising from these injuries.

- Assisting children to recover from complications arising from acute infection and accelerating reintegration into daily activities, such as school and sport, by improving joint movement, mobility and function.

- Designing exercise programs which, in conjunction with a healthy diet, can help recover or maintain a proper body weight. The APA Position Statement on Physical Activity and Healthy Weight for Children (Appendix 1) describes the role that physiotherapy can play in weight management.

The introduction of an Indigenous child health check provides an excellent opportunity to increase Indigenous access to physiotherapy services, particularly preventive services, and to achieve better health outcomes for Indigenous children.

This opportunity is especially important in regional and remote areas. In order to provide physiotherapy to remote Indigenous communities it is essential that outreach services are available and that they are provided as part of a multidisciplinary team. Allowance should be made for appropriate remuneration to acknowledge the travel time of the team. Consideration should also be given to providing access to services such as occupational therapy, mental health services, dietetics, and podiatry, if indicated by an adult or child Indigenous health check.

Recommendations:

3. That a physiotherapy MBS item be introduced for the treatment of Indigenous children, on referral from the GP conducting the Indigenous child health check.

4. That an outreach physiotherapy MBS item be introduced for the treatment of Indigenous children, on referral from the GP conducting the Indigenous child health check.

5. That similar items be created for therapy and preventive care for adults who have an Indigenous adult health check (MBS item 710) billed.

Evidence-based funding

There is growing evidence that physiotherapy interventions for the management of certain conditions are as effective as, and more cost effective than, many medical and surgical interventions currently covered by the MBS. The APA supports the creation of MBS items for these physiotherapy interventions. Importantly, access to physiotherapy items for the management

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Cole J (2001) Effect of a developmental program on motor performance in infants born preterm. *Australian Journal of Physiotherapy* 47:169-176.

of certain conditions will provide consumers with the ability to choose the appropriate treatment and provider for their health needs. Below are three examples of such interventions; the APA would be pleased to present more examples on request.

Continence physiotherapy vs surgery

There is a substantial body of evidence of the efficacy of physiotherapy in continence management. One of the most recent studies, published in the Australia and New Zealand Journal of Obstetrics and Gynaecology, found that 82% of women were cured of stress urinary incontinence after one episode of physiotherapy care[16]. Another study found that physiotherapy management of female stress urinary incontinence costs on average $302.40 while surgical management costs between $4668 and $6124.[17]

In addition to being less cost effective, surgical management also requires a substantially greater workforce contribution by more highly trained staff. For example, the surgeon would be a sub-specialist urogynaecologist who would have a minimum of 15 years training, a specialist anaesthetist would have a minimum of 12 years training, and there would be input from nursing and health support workers. Bo comparison, the continence physiotherapist would have four years undergraduate training with two or more additional years of training or experience.

Physiotherapy for chronic low back pain vs spinal fusion

A recent study compared two types of treatment for chronic low back pain - surgical stabilisation of the spine versus intensive physiotherapy rehabilitation. The study concluded that 'no clear evidence emerged that primary fusion was any more beneficial than intensive rehabilitation'[18]. Since surgery poses considerable risks and is resource intensive a further analysis was undertaken to compare the cost effectiveness of the two treatments. It was found that the mean total cost per patient in the surgery group was £7830 and in the physiotherapy group was £4526[19]. It is not economically rational that a treatment of equal benefit and nearly half the cost is not funded by the MBS.

Physiotherapy for neck pain vs GP care

Recent evidence in the *British Medical Journal* supports the cost effectiveness of physiotherapy as opposed to GP care for the treatment of neck pain. Manual therapy – a physiotherapy modality – was found to be not only the most effective treatment, but also the cheapest at a third of the cost of GP

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[16] Neumann PB, Grimmer KA, Grant RE and Gill VA (2005): Physiotherapy for female stress urinary incontinence: a multicentre observational study. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 45(3): 226–232.
[17] Neumann PB, Grimmer KA, Grant RE and Gill VA (2005) The costs and benefits of physiotherapy as first-line treatment for female stress urinary incontinence. *Australian and New Zealand Journal of Public Health* 29(5):416-421
18 Fairbank, J et al (2005) Randomised controlled trail to compare surgical stabilisation of the lumbar spine with an intensive rehabilitation programme for patients with chronic low back pain: the MRC spine stabilisation trial. *British Medical Journal* 330 (7502): 1233.
19 Rivero-Arias, O et al (2005) Surgical stabilisation of the spine compared with a programme of intensive rehabilitation for the management of patients with chronic low back pain: cost utility analysis based on a randomised controlled trial. *British Medical Journal* 330 (7502): 1239.

care. Manual therapy cost €447 compared to GP care which cost €1379[20]. In this instance the current MBS system, that funds GP care and not physiotherapy care, provides a disincentive for the public to seek the clinically successful and economic health care option.

There are many such interventions in a range of disciplines. It is a demonstrably false economy for such interventions not to be funded by the MBS.

Recommendation:

6. That new MBS items be introduced for the management of specified conditions by specified practitioners where there is evidence of the effectiveness and cost effectiveness of the intervention.

FUND POOLING

The current funding arrangements between states and territories, the Commonwealth and local governments are confusing to consumers and providers alike. They lead to inefficiencies, service gaps and inequitable levels of service delivery, with concomitant inequitable outcomes for Australians. The APA supports a single funder for all services, with allocation decisions being made at a local level. Ideally that funder would be the Commonwealth but, acknowledging the unlikeliness of this eventuating in the current environment, the APA supports a state/Commonwealth funding pool out of which funds could be allocated.

Aside from reducing blame shifting and providing for a co-ordinated approach to the funding of health services, pooling would also allow for innovative service delivery models to be trialled and, where proven effective, rolled out elsewhere.

Health service delivery, particularly in primary care, is improved when delivered by multidisciplinary teams.[21] The multidisciplinary approach in primary care is becoming more important as the body of health care knowledge continues to grow beyond that which it is possible for one person to learn. It is particularly useful in the management of chronic diseases, acute musculoskeletal injury and a range of syndromes and neurological disorders.

A range of surveys of general practitioners during recent years have indicated that GPs value the involvement of physiotherapists in multidisciplinary teams. For example, when asked about improving quality of care for musculoskeletal conditions, 85% of GPs said that more resources for primary care physiotherapy would lead to reduced prescription of non-steroidal anti-

20 Korthalas-de Bos, I et al (2003) Cost effectiveness of physiotherapy, manual therapy, and general practitioner care for neck pain: economic evaluation alongside a randomised controlled trial. *British Medical Journal* 326 (7395): 911-014.

21 Saunders D. Primary Health Care and Population Health: an international perspective. Presentation at Public Health Education and Research Workshop, Canberra, 3 May 2002.

inflammatory drugs.[22] This would reduce the strain on the Pharmaceutical Benefits Scheme and avoid exposing patients to the unwanted side effects of these medications.

Multidisciplinary teams have also proven effective in rural and regional settings in terms of improving the quality of care, attracting and retaining health care professionals[23] and in providing support and encouragement for team members. What is more, multidisciplinary approaches promote safe health care and are preferred by consumers as they promote patient-centred care.[24]

The division of responsibility between states (largely funding hospital services) and the Commonwealth (largely providing rebates on fee-for-service consultations) does not itself lead to the provision of multidisciplinary services in the community. Some states are trialling care centres but their structures are based on available funding rather than on best practice or consumer convenience.

Divisions of primary care

Although Divisions of General Practice were originally intended to support GPs, most Divisions have evolved into fund-holders which allocate funds from various government programs to pay for the provision of health services in the community.[25]

Various Commonwealth and state-based schemes provide funds to Divisions to purchase allied health services. Such schemes are evidence of the recognition of the need for multidisciplinary care and of the unmet need for allied health services. However, resultant multidisciplinary service delivery via Divisions is patchy, unco-ordinated, inequitable, and often ineffective. Services delivered are generally those that local GPs value, which are most often delivered by

Most importantly, the governance and funding models employed by many Divisions are not conducive to effective multidisciplinary teamwork. The boards of governance of most Divisions are almost exclusively comprised of medical practitioners and retain a focus on general practice rather than on multidisciplinary practice. For the year 2003–04, only eight percent of board members of Divisions were not GPs.[26] There are no equivalent data in the most recent ADGP Annual Report but anecdotally it is clear that the vast majority of Division board members are GPs and no Divisions have opened

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[22] Roberts C, Adebajo AO, Long S.(2002) Improving quality of care of musculoskeletal conditions in primary care. *Rheumatology* :41;503.
[23] Taylor J, Blue I, Misan G. Approaches to sustainable primary health care service delivery in rural and remote South Australia. *Aust J Rural Health* 2001:9;304.
[24] Safety and Quality Council, Consumer Vision for a Safer Health Care System. Report of a consumer workshop, Sydney, 17 May 2001.
http://www.safetyandquality.org/articles/Publications/consumer.pdf
[25] See ~~http://www.phcris.org.au/products/asd/index.php~~ data from the annual survey of divisions.
[26] ADGP Annual Report 2003–04.

up membership to other primary care clinicians. Funding for GP services remains on a fee-for-service basis while other health practitioners are remunerated by whatever model the Divisions determine. This exacerbates the fragmentation fosters unequal relationships between members of the health care team.

It is time for Divisions to evolve further and become Divisions of Primary Care. Divisions of Primary Care could support all members of the multidisciplinary healthcare team and act as fund-holders for local primary care services.

Pooled funding would allow Divisions to engage health practitioners, including GPs, on the basis best able to meet community needs. That is, service planning can be predicated on meeting need instead of how to access funds available from existing Commonwealth, State or local programs. Pooled funding could also cover services for which there is currently no payment mechanism. For instance there is currently no funding for health professionals other than doctors to participate in care planning or case conferencing. Pooled funding could cover this cost, thus facilitating better multidisciplinary care planning.

To date, two divisions have been renamed as 'Divisions of Primary Health Care' and one is a 'Division of General Practice and Primary Health'.[27] None of these Divisions has a governance structure reflecting their title but it must be acknowledged that they are a step closer to supporting primary care than the remaining 115 divisions who have made no change whatsoever.

Divisions prepared to embrace a key role in the delivery of multidisciplinary care, as opposed to operating with a predominant focus on the needs of general practitioners, should be provided with funds to enable the purchase of co-ordinated multidisciplinary services. Divisions prepared to undertake this role should be regulated to ensure they adopt governance models reflective of the multidisciplinary clinical practice. Membership of Divisions of Primary Care should be opened up to all registered primary care providers within the catchment area and it should be required that Board membership include consumers and health professionals other than GPs.

Recommendation:

7. That Divisions of General Practice be transformed into Divisions of Primary Care with membership open to all registered health professionals and a governance structure which reflects this diversity. Divisions of Primary Care should receive funding from a state/Commonwealth funding pool to deliver multidisciplinary services.

Multidisciplinary care centres

The APA contends that fund pooling would allow for the establishment of community-based multidisciplinary care centres, away from tertiary hospitals,

[27] ADGP Annual Report 2004–05.

where patients could attend for 'one-stop-shop' service. Such centres could initially provide best practice treatment for specified chronic illnesses such as diabetes, cancer and heart disease. If the model proved successful the cohort of eligible patients could be expanded.

Centres could operate as first contact facilities, with triage professionals assessing clinical eligibility then referring patients to the appropriate health professional to manage their care. The selected clinician could confirm the triage professional's differential diagnosis and work with the patient to develop a care plan.

The facilities could be staffed by salaried health care and administrative staff. Centres would be appropriate learning environments for student clinical education and internships. They could also operate as centres for public health education.

Ideally centres would be funded centrally (via pooled funding) and governed locally by community representatives with input from salaried staff such as GPs, nurses, physiotherapists and psychologists. Such governance would ensure that the community has input to the service mix necessary to meet local needs.

Multidisciplinary care centres would provide chronically ill Australians with access to all the services they need to manage their conditions. Pooled funding would allow service design to be based on clinical requirements and not just on the programs currently available.

The philosophy of the centres should be to promote self management to the greatest extent possible and to provide best practice care at the lowest possible cost. A condition of accessing the centres could be that patients agree to try the most cost effective available treatment first, only moving to more expensive treatments if the cheaper option fails.

Recommendation:

8. That the state and Commonwealth funds be pooled to trial a multidisciplinary care centre in each state and territory.

CITIZEN ENGAGEMENT

The APA supports accountability to the community by the deliverers of all health services. Consumer involvement in health services improves not only the quality of services provided but also the capacity of the service to meet the needs of the community it serves. The Consumers' Health Forum[28] has produced a range of publications demonstrating the benefits of consumer involvement which the APA endorses.

[28] See http://www.chf.org.au/index.asp

It is impossible to fund all of Australia's health care needs so decisions about allocation of funds need to be made. The APA contends that these decisions should be directed by well informed citizens who are selected at random to consider health resource allocation. A range of methodologies have been developed to ensure that individuals selected are provided with the information and support necessary to provide an independent citizen perspective as opposed to a biased individual consumer perspective. International experience, such as the Romanow Commission in Canada[29], demonstrates that not only are citizens willing to engage in the decision making process but they are also able to distinguish between their individual needs and those of the community.

The APA strongly supports citizen engagement in the process of allocating health funding. Many engagement mechanisms are available, such as citizens' juries, citizens' assemblies, consensus conferences, deliberative polls, and tele-voting. Citizens' juries have been trialled in Western Australia[30], with the resultant decisions being implemented at present. Consumer engagement strategies have been used to positive effect all over the world: it is time that Australia followed the lead and involved its citizens in health funding decisions.

Recommendation:

9. That the Commonwealth fund a process of citizen engagement in decision making about the allocation of health funding.

REGULATION OF PRIVATE HEALTH INSURANCE

APA members regularly report that their patients are dissatisfied with two specific aspects of the operation of health funds:

- The difficulties associated with changing funds; and
- The fact that rebate arrangements can be changed without a notice period.

Most funds insist on a 12-month waiting period before rebating treatment for pre-existing conditions, even when an individual is changing funds. Thus a patient in the middle of a course of treatment or who has a chronic condition cannot change funds without forgoing 12 months of rebates. So even if a fund is no longer suitable, the patient must remain with that fund or lose rebates.

Many patients select policies because, for example, they provide a good rebate for physiotherapy. When a fund informs a patient that a rebate will be lowered (usually forthwith), the patient is no longer gaining value for money

[29] See http://www.hc-sc.gc.ca/english/care/romanow/hcc0086.html
[30] Mooney, GH and Blackwell SH (2004): Whose health is it anyway? Community values in healthcare. *Medical Journal of Australia* 180: 76-78.

from the insurance premium. The waiting period issue mentioned above further complicates the situation. That is, if a fund reduces the rebate for physiotherapy while the patient is receiving treatment, the patient has the choice of accepting the lower rebate, or changing to another fund and waiting 12 months before they can receive a rebate.

Recommendation:

10. That health insurance funds be required to waive the 12-month waiting period for pre-existing conditions for individuals who have current policies with other funds.

11. That health insurance funds be required to give a statutory notice period before reducing existing rebate arrangements.

CONCLUSION

Australia provides excellent health services but in an inefficient manner. Some sections of our community do not receive the level of service necessary to ensure reasonable outcomes and the Indigenous community is the most notable example of this problem.

This submission does not propose to solve all the problems of Australia's health system. Rather it makes some practical suggestions to the Committee on how to improve service delivery in the community and recommends the involvement of the community in decisions related to major reform.

None of these changes will be of much benefit unless Australia utilises its health workforce completely for without complete utilisation of health professional skills there will not be enough service providers to meet care needs. The APA thus encourages the committee to endorse the recommendations of the Productivity Commission's Health Workforce Research Report in addition to making its own recommendations.

ABOUT THE APA

The Australian Physiotherapy Association (APA) is the voice of the physiotherapy profession in Australia and leads the profession internationally. Physiotherapists must be fully qualified and eligible for registration with the Physiotherapists' Registration Board in their respective state or territory to be eligible for full APA membership. Australia has approximately 11 300 registered practising physiotherapists. The APA has more than 11 000 members. The APA national office is located in Melbourne, with branch offices in every state and territory. Further information on the APA is available at www.physiotherapy.asn.au